Student Accident Claims Overview

- NEW Claim Forms
- Supplemental coverage under your GL
- Secondary to any other insurance
- Claims handled by experienced professionals
- **Claims must be received within 90 days**

Student Accident Claims Reporting Process

Action Items when Student is Injured at School*

- Complete internal incident report
- Complete school section of claim form
- Provide claim form to parent for signature
- Forward signed form within 90 days to VACORP
- VACORP will contact parent for information, bills

*School-sponsored event/activity. Athletics may be added

Claim Form Part 1: Incident Information

This form must be returned **to the School within 90 days from the date of incident**. VACORP will send parents information on submitting bills and EOBs for consideration on applicable claims *(School will not accept bills or EOB documentation)*.

VACORP
(888) 822-6772

STUDENT ACCIDENT CLAIM FORM

Student Accident Coverage is SECONDARY to any other insurance, including Medicaid, FAMIS, or private health insurance.

PART 1: INCIDENT INFORMATION (TO BE COMPLETED BY THE SCHOOL)

School Division: _____
School Name: _____
School Address: _____
Student's Name: _____

☐ Male ☐ Female Date of Injury: _____ Date of Birth: _____

Grade Level: _____
Body Part: _____

Description of Accident (Include an additional page if needed):

_____

_____

_____

If Athletics, please indicate the sport:

At the time of injury, was the student involved in a School Division sponsored activity? ☐ Yes ☐ No
Under whose supervision? _____ Phone #: _____

Signature of Preparer: _____ Title: _____
Printed Name: _____ Date: _____ Phone #: _____

Claim Form Part 2: Parent Information

PART 2: PARENT INFORMATION (TO BE COMPLETED BY THE PARENT, PLEASE INCLUDE BOTH *STUDENT* AND *PARENT* INFORMATION)

Student Information:

Student Address: _____

Parent Information:

Father's Name: _____ Phone #: _____

Father's Employer: _____

Employer's Address: _____

Mother's Name: _____ Phone #: _____

Mother's Employer: _____

Employer's Address: _____

Please list **ALL** insurance policies: ☐ Check if No Insurance

Name of Insurer: _____

Address: _____ Policy #: _____

Phone #: _____ ☐ Group ☐ Individual

Treatment Information:

Physician/ Facility Name: _____

Address of Physician/ Facility: _____

Phone #: _____ Date Seen By Physician/ Facility: _____

Claim Form Page 2: Claim Instructions

Instructions:
In case of an accident, notify the school immediately.

1. Complete this claim form and return it to the school within 90 days from the date of injury.
2. Please include information on any available health care insurance, including Medicaid.
3. In order to process this claim for payment, VACORP will need itemized bills and all Explanations of Benefits (EOB) showing what your insurance has paid. Statements without itemized information will not be accepted.
4. When you receive your EOB, send it to VACORP, along with the corresponding itemized statements. We will pay benefits for eligible expenses per the terms of the contract.
5. Benefits are paid directly to the providers of service unless VACORP receives paid receipts.

Student Accident coverage is only available to cover students for accidental injury occurring while the contract is in force.

Benefits are provided on a ***SECONDARY*** excess basis for covered expenses **incurred and reported** within one year after the date of the accident.

Benefits are payable up to the applicable maximum for the covered expenses that are in excess of other valid and collectible insurance including: Medicaid, Medicare, FAMIS and private health insurance.

This claim form must be submitted to VACORP by the school division prior to any bills being reviewed or processed.

If your medical coverage is under an HMO, PPO or similar plan, you must follow their requirements for obtaining benefits; otherwise, VACORP's benefits may be reduced, where applicable, as stated in the contract provisions.

Claim Form Page 2: Parent Authorization

AUTHORIZATION FOR RELEASE OF INFORMATION: I AUTHORIZE any physician, medical care provider, hospital, clinic, medical care facility, insurance company, government-sponsored health plan, or employee having information available as to diagnosis, treatment and prognosis with respect to any illness, injury, physical or mental condition, and/or treatment for me or my minor children now or in the past, to give to VACO Group Self-Insurance Risk Pool (VACORP) or its legal representative, any and all such information.

I UNDERSTAND the information obtained will be used by VACORP to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by VACORP to any person or organization except as necessary tin connection with the processing of this application, claim or as may be otherwise lawfully required or as I may further authorize. I further understand that I may request to receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original. I also AGREE this Authorization shall be valid for a period of two years from the date shown below. I may revoke this authorization at any time by written request to VACORP.

I CERTIFY that the information given by me in support of this claim is true and correct.

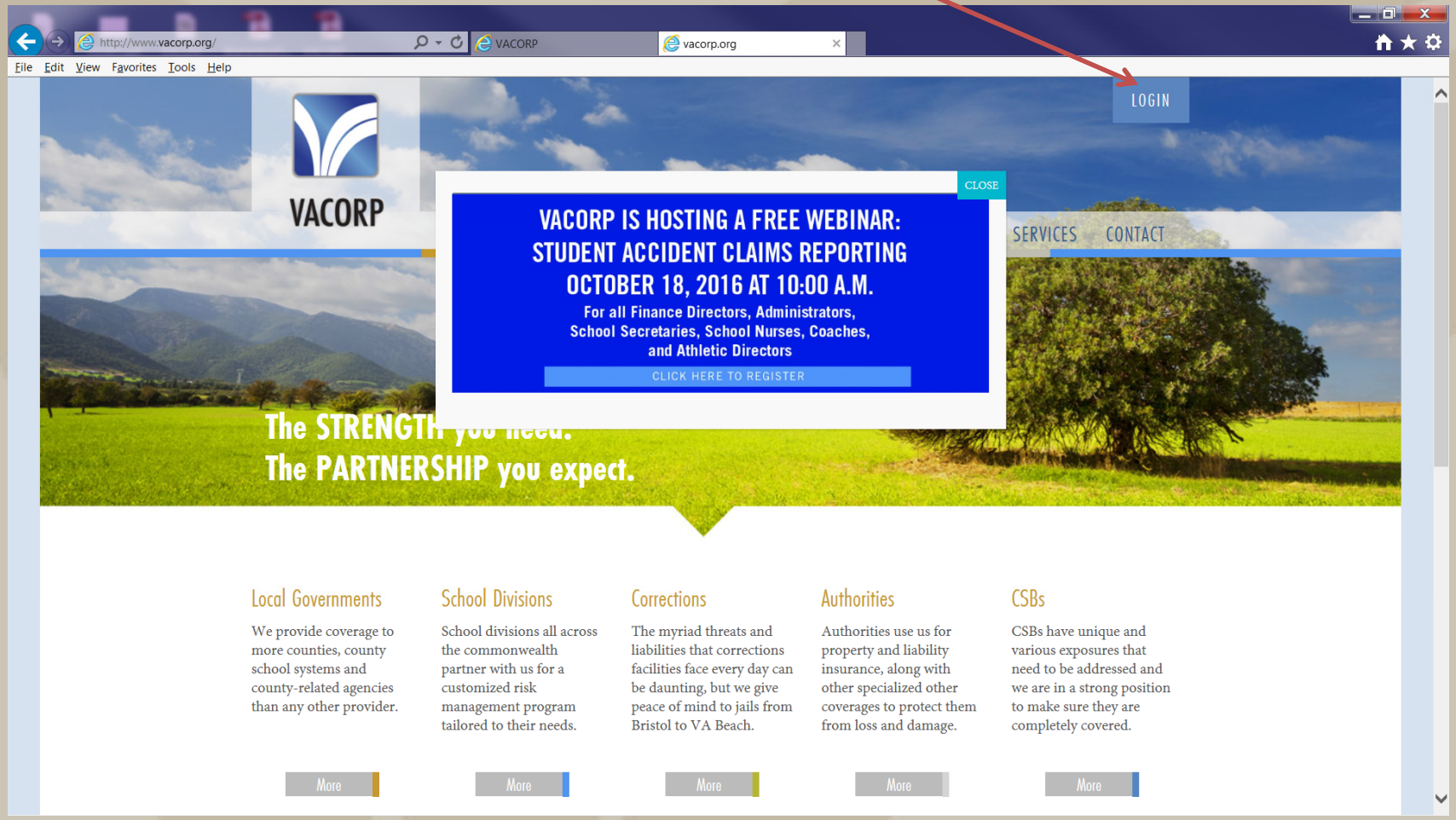
Any payment will be made to the service provider (hospital, physician, and others) unless a paid receipt or statement accompanies the bill when the claim is submitted to VACORP.

AFFIDAVIT: I verify that the statement in Part 2 about other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via US Mail may be fraudulent and violate federal and state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim, I will reimburse VACORP to the extent VACORP made a payment for which it was not obligated under the contract.

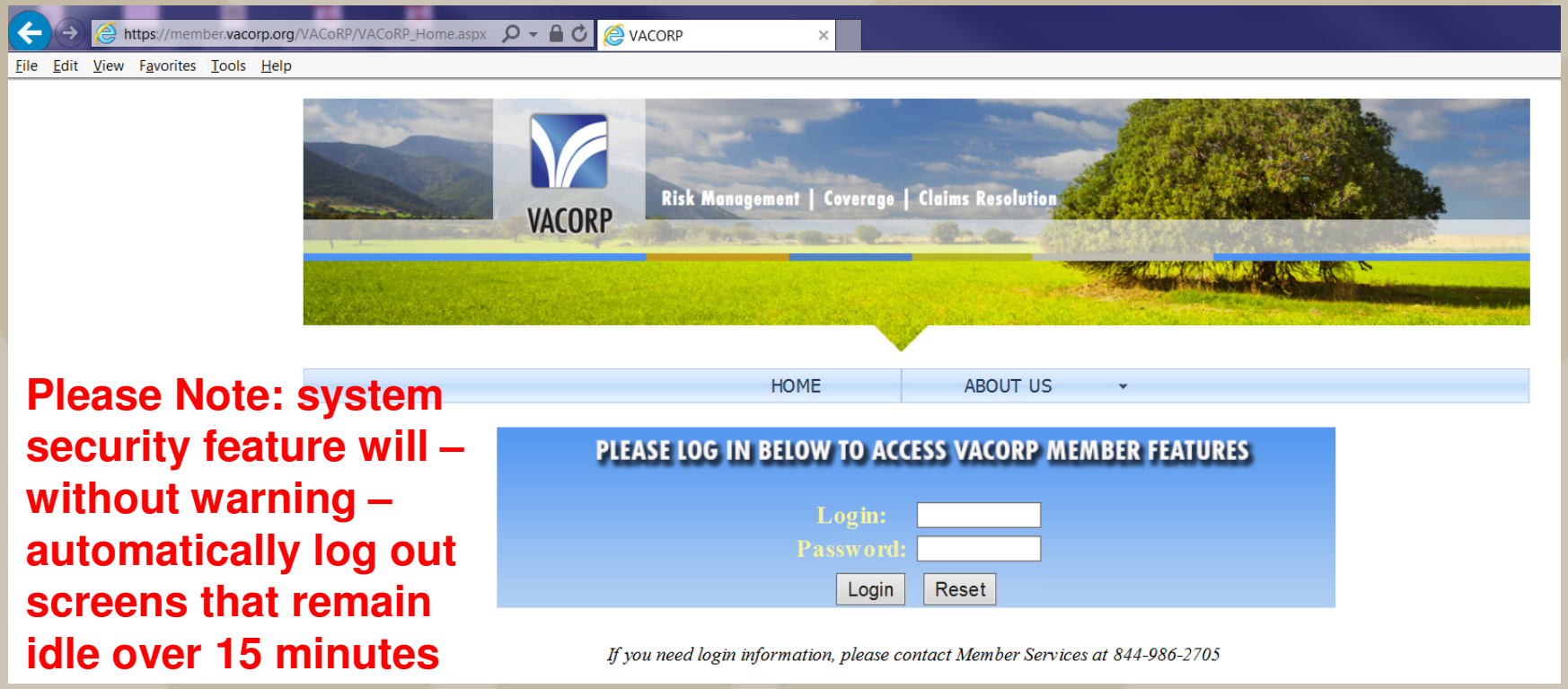
Parent or Authorized Representative's Signature: _____ Date: _____

If Authorized Representative, Relationship to Student or Legal Designation: _____

Reporting Claims Online

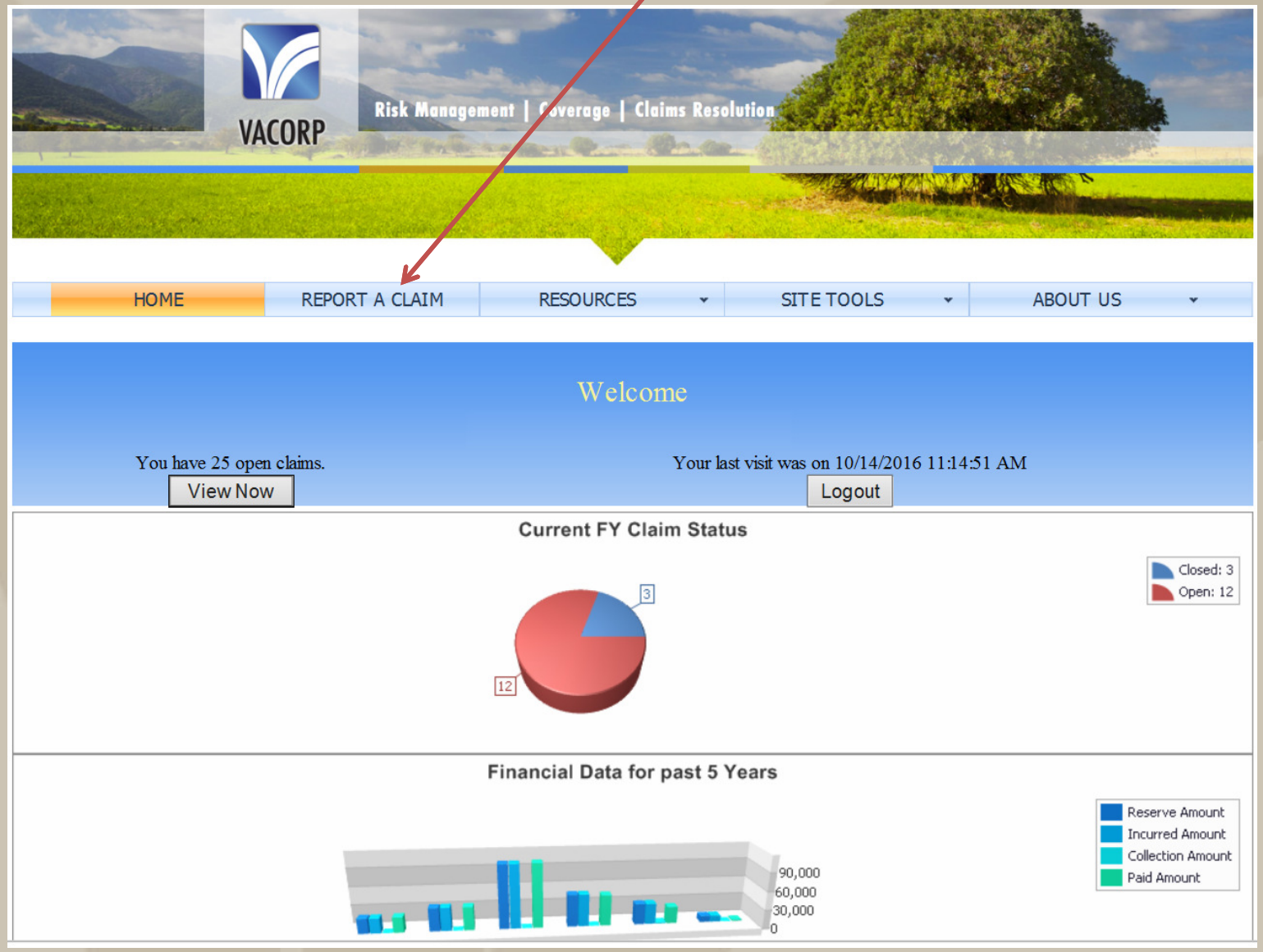


Reporting Claims Online



Please Note: system security feature will – without warning – automatically log out screens that remain idle over 15 minutes

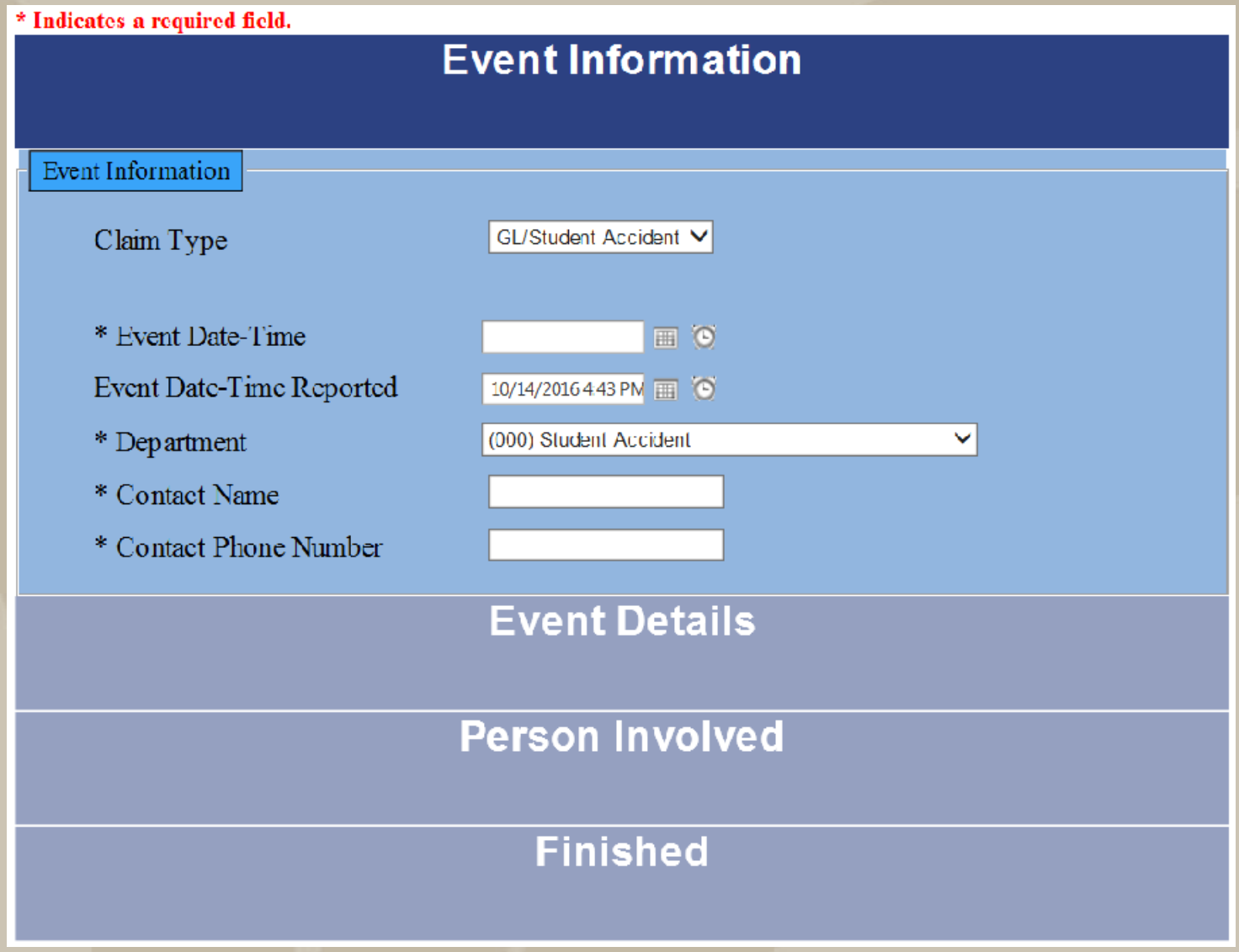
Reporting Claims Online



Reporting Claims Online

- Go to www.VACORP.org and login. Select “Report a Claim” link located in the menu bar at top of the page. Clicking this link will open a **new window** and present four boxes labeled as follows:
  - Event Information
  - Event Details
  - Person Involved
  - Finished
- To report a claim, complete as much information as possible. Since the claim details will be included on the Claim Form, you must complete fields marked with an asterisk (*), before the claim may be submitted.

Claim Data Entry Box 1: Event Information



Claim Data Entry Box 1: Event Information

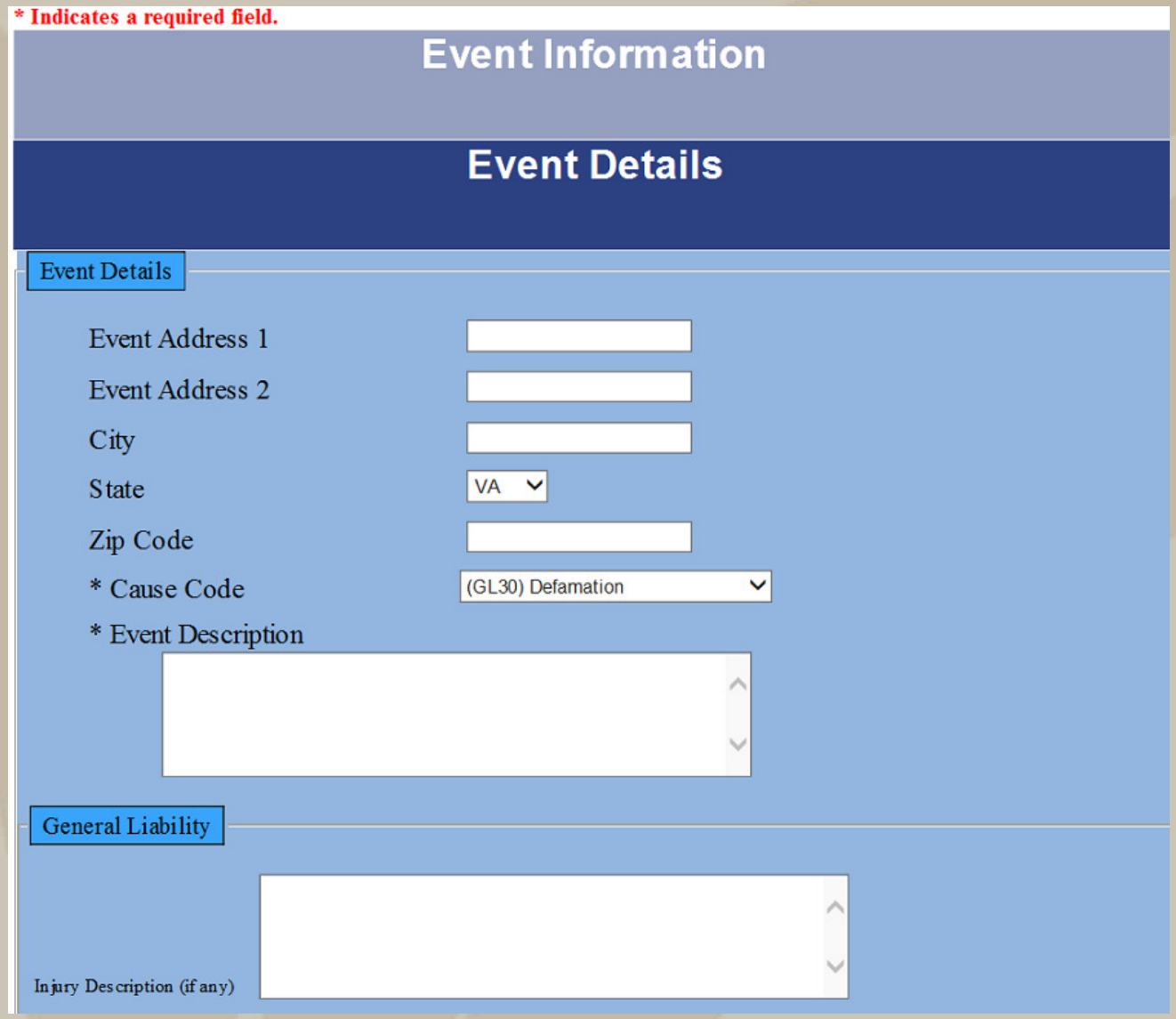
- Claim Type: Default is Student Accident
- Event Date – Time: click on calendar/clock
- Department: Student Accident
- Enter Contact Name and Phone Number of the school division employee that can best answer questions about the claim

Claim Data Entry Box 2: Event Details

Fields with * must be completed, but provide as much information as available.

- Cause Code: select best match
- Event Description: enter brief description or indicate “see attached claim form”

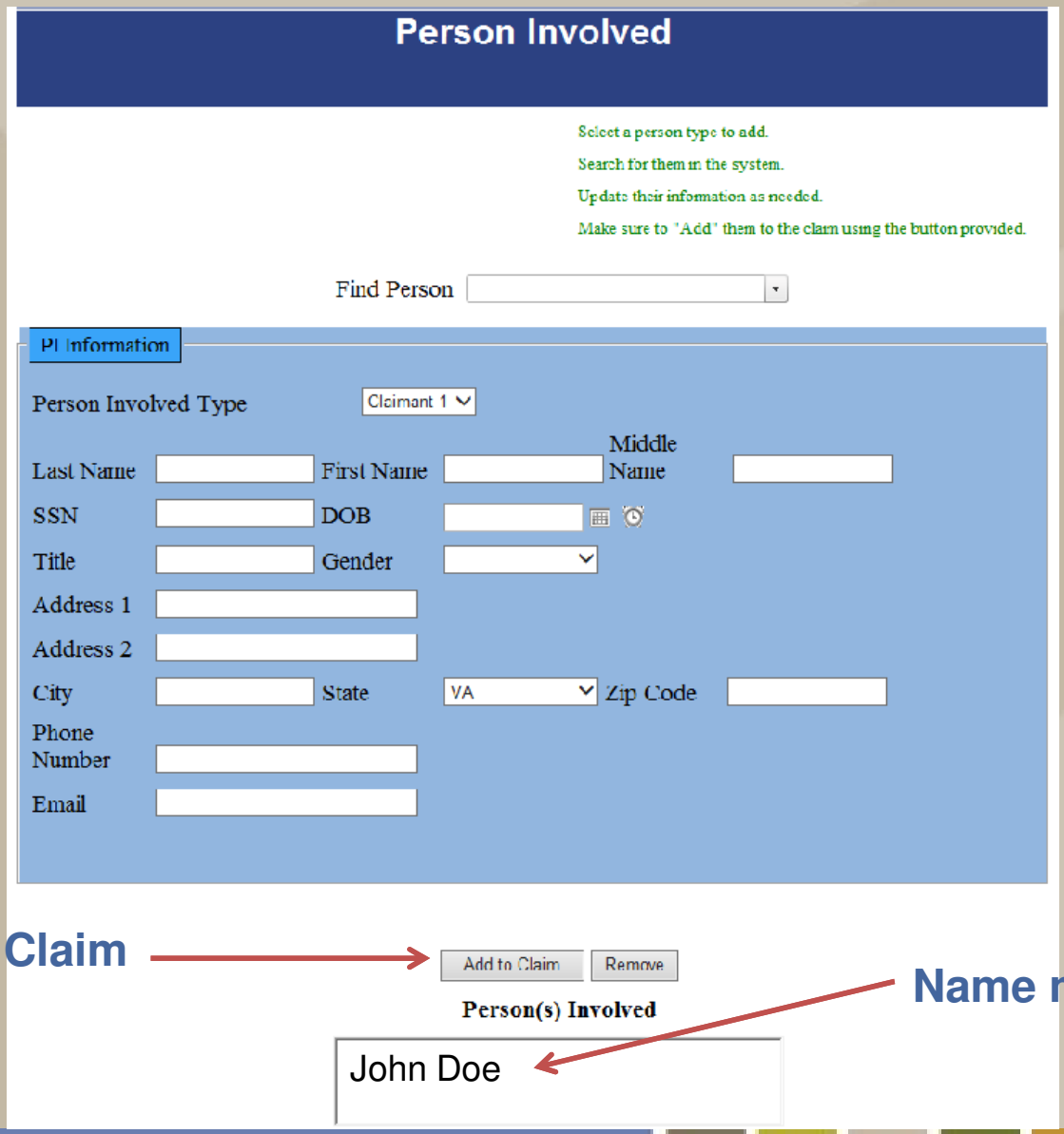
Claim Data Entry Box 2: Event Details



Claim Data Entry Box 3: Persons Involved

- Enter Student Information - REQUIRED
  - First and Last Name
  - Address
  - Phone Number
- Must click “Add to Claim” for info to be saved
- Other info will be on claim form submitted

Claim Data Entry Box 3: Persons Involved



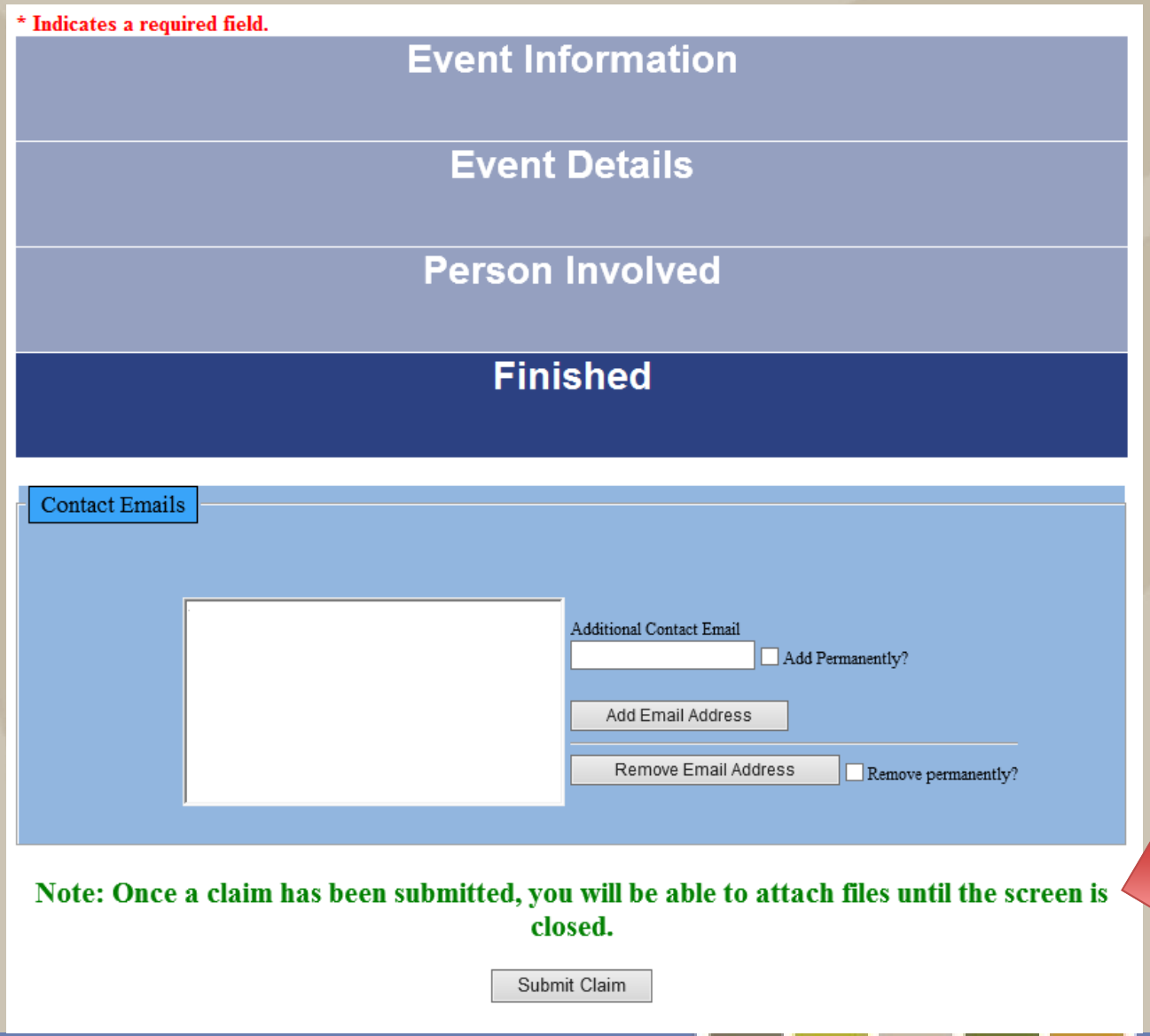
Click Add to Claim

Name must appear in box

Claim Data Entry Box 4: Finished

- Enter email address for person(s) to receive confirmation email from VACORP
- Click Submit Claim for **unique claim number**
- Select Upload Attachment and find the claim form (and other documents) saved to your device
- After closing the window, send additional documents marked with claim number to Tech1@riskprograms.com

Claim Data Entry Box 4: Finished



Schedule of Benefits - Student Accident Claims

Benefit	Standard	Economy	Deluxe
Medical expense limit	$5,000	$10,000	$25,000
Inpatient room and board – usual and customary (U&C) – semiprivate room	$300 first day $150 each additional day	$500 first day $300 each additional day	$1000 first day $700 each additional day
Day surgery	up to $500	up to $1,000	up to $1,500
Outpatient Physician visit expense	$20	$30	$50
Outpatient Physiotherapy expense	$20/day up to $100	$30/day up to $250	$50/day up to $500
Outpatient Emergency Room expense	up to $250	up to $500	up to $750
Outpatient X-Ray expense	up to $100	up to $250	up to $500
Laboratory	U&C	U&C	U&C
Prescriptions	U&C	U&C	U&C
Outpatient durable medical equipment and supplies expense	up to $100	up to $200	up to $300
Surgeon expense	U&C up to $1,000	U&C up to $2,000	U&C up to $3,000
Assistant surgeon	30% of amount paid for surgery	30% of amount paid for surgery	30% of amount paid for surgery
Anesthetist or Anesthesiologist expense	30% of amount paid for surgery	30% of amount paid for surgery	30% of amount paid for surgery
Ambulance expense	up to $100	up to $250	up to $500
Consultant	up to $100	up to $250	up to $500
Outpatient Dental Accident Expense	$150 per tooth $600 max	$250 per tooth	$600 per tooth
Licensed Nurse Expense	$70 per day	U&C	U&C
Motor Vehicle Accident Expense	$500	$1,000	$2,000
Heat Exhaustion and Sunstroke	$100	$500	$1,000

Student Accident Claims Recap

- VACORP is secondary to any other insurance
- Claims handled by knowledgeable professionals
- Follow-up info may be sent to tech1@riskprograms.com
  - additional documents, medical bills, EOBs
  - write school division name and claim number on all correspondence
    - » last 5 digits are unique identifier

NEW Catastrophic Student Accident Program

- Fills coverage gaps of VHSL Cat Program
- Limits available up to $3,000,000
- Coverage is secondary to other insurance
- $25,000 deductible
  - Out of Season Sports Practices and Scrimmages
  - Middle School Sports
  - Catastrophic Injuries
- Report claims as soon as possible

Catastrophic Student Accident Claim Form

Please select one of the following: ☐ **Fatality** ☐ **Catastrophic Claim**

PART 1: INCIDENT INFORMATION (TO BE COMPLETED BY THE SCHOOL)

School Division: _____

School Name: _____

School Address: _____

Student's Name: _____

☐ Male ☐ Female Date of Injury/Fatality _____ Date of Birth: _____

Grade Level: _____

Body Part: _____

Description of Accident (Include an additional page if needed):

_____

_____

_____

If Athletics, please indicate the sport:

At the time of injury, was the student involved in a School Division sponsored activity? ☐ Yes ☐ No

Under whose supervision? _____ Phone #: _____

Signature of Preparer: _____ Title: _____

Printed Name: _____ Date: _____ Phone #: _____

Catastrophic Student Accident Claim Form

PART 2: PARENT INFORMATION (TO BE COMPLETED BY THE PARENT, PLEASE INCLUDE BOTH *STUDENT* AND *PARENT* INFORMATION)

Student Information:

Student Address: _____

Parent Information:

Father's Name: _____ Phone #: _____

Father's Employer: _____

Employer's Address: _____

Mother's Name: _____ Phone #: _____

Mother's Employer: _____

Employer's Address: _____

Please list **ALL** insurance policies: ☐ Check if No Insurance

Name of Insurer: _____

Address: _____ Policy #: _____

Phone #: _____ ☐ Group ☐ Individual

Catastrophic Student Accident Claim Form

Treatment Information:
Physician/ Facility Name: _____
Address of Physician/ Facility: _____
Phone #: _____ Date Seen By Physician/ Facility: _____

Name and addresses of doctors attending the deceased following the accident:
Doctor: _____ Address: _____
Doctor: _____ Address: _____
Doctor: _____ Address: _____
Doctor: _____ Address: _____

Was this accident reported to the police department? ☐ Yes ☐ No If yes, indicate the name of the police department _____

Was an autopsy held? ☐ Yes ☐ No If so, who conducted the autopsy (Name and address):

Did the deceased have any chronic disease, physical defects or deformities? ☐ Yes ☐ No If yes, please describe:

Catastrophic Student Accident Claim Form

Instructions:

In case of an accident, notify the school immediately.

1. Complete this claim form and return it to the school within 180 days from the date of injury.
2. Please include information on any available health care insurance, including Medicaid.
3. In order to process this claim for payment, VACORP will need itemized bills and all Explanations of Benefits (EOB) showing what your insurance has paid. Statements without itemized information will not be accepted.
4. When you receive your EOB, send it to VACORP, along with the corresponding itemized statements. We will pay benefits for eligible expenses per the terms of the contract.
5. Benefits are paid directly to the providers of service unless VACORP receives paid receipts.

Student Accident coverage is only available to cover students for accidental injury occurring while the contract is in force.

Benefits are provided on a ***SECONDARY*** excess basis for covered expenses **incurred and reported** within one year after the date of the accident.

Benefits are payable up to the applicable maximum for the covered expenses that are in excess of other valid and collectible insurance including: Medicaid, Medicare, FAMIS and private health insurance.

This claim form must be submitted to VACORP by the school division prior to any bills being reviewed or processed.

If your medical coverage is under an HMO, PPO or similar plan, you must follow their requirements for obtaining benefits; otherwise, VACORP's benefits may be reduced, where applicable, as stated in the contract provisions.

Required:

Please attach a copy of the death certificate to this form once the form has been completed and is ready to be returned to VACORP.

Catastrophic Student Accident Claim Form

AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize all medical service sources and health care providers to disclose a complete copy of my health records, including records related to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse to Virginia Association of Counties Group Self-Insurance Risk Pool, its subsidiaries and affiliates, its claim associates, and legal representatives (hereinafter referred to collectively as VACORP).

I authorize the use of the above information for VACORP to investigate, process and determine the amount payable, if any, for all claims made under any VACORP property and casualty contract that applies to the accident or occurrence on _____. I understand as part of the claim handling process, VACORP may disclose medical or other information obtained by this authorization to physicians, dentists, other medical or healthcare providers or other professional for their review and professional opinion. This information may also be released to other insurance companies for their use in connection with insurance transactions, or as required or permitted by law. Information obtained pursuant to this authorization may later be redisclosed and may not be

protected under the HIPAA privacy rule. I understand that I may refuse to authorize disclosure of all or some of the requested information, but that refusal may potentially cause a delay in processing, or result in the denial of, insurance benefits for the pending injury claim(s).

This authorization may be revoked at any time, except to the extent that VACORP has taken action in reliance on this authorization prior to notice of revocation. Such revocation must be in writing, dated, signed, and include the claim number referenced above. I understand that revocation of this authorization may potentially cause a delay in processing, or result in the denial of, insurance benefits for the pending injury claim(s). This authorization is valid for the duration of the claim referenced above, and a photocopy is as valid as the original. This authorization specifically applies to records made before, during, and after the date of signing this authorization for as long as the authorization is in effect.

I have read the authorization and singed this document. I verify that the statement in Part 2 about other insurance is accurate and complete. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse VACORP to the extent VACORP made a payment for which it was not obligated under the contract. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Review – Student Accident Claims & CAT program

- Report claims within 90 days of injury
- Coverage is secondary to other insurance
- Contact your Central Office or Member Services for login
- Scan/Save claim form/other documents before login
- Claim inquiries call customer services line 888-822-6772
- Coverage available for Catastrophic injuries and death
  - Out of Season sports practices and scrimmages
  - Middle School sports
  - Tragic accidents, such as lab explosions
  - $25,000 deductible

The STRENGTH you need.

The PARTNERSHIP you expect.

Questions

Thank you for attending today's webinar!
For additional information, please contact Member Services at 844-986-2705 or info@riskprograms.com
For information about a claim please call our Customer Services Line at 888-822-6772